Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PRICILLA KEATING

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-15-3468-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
JUNE 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Printed and faxed claim with documentation originally March 4th, 2015. Claim was never addressed. Faxed claim again on 6/10/15 with fax cover sheet stating 'second submission of claim with fax confirmation sheet to prove timely filing'…Claim was filed timely as there is proof of timely filing and should be paid."

Amount in Dispute: $200.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier maintains the dispute due to untimely filing."

Response Submitted By: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 24, 2015	CPT Code 97001-GP Physical therapy evaluation	$200.00	$114.27
	CPT Code G8985-GP-CL Carrying, moving and handling objects, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	$0.01	$0.00
	CPT Code G8984-GP-CN Carrying, moving and handling objects functional limitation, current status, at therapy episode outset and at reporting intervals	$0.01	$0.00
TOTAL		$200.02	$114.27

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim

by a health care provider.

2. 28 Texas Administrative Code §133.307, effective June 1, 2012 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §133.20, effective January 29, 2009, 34 *Texas Register* 430, sets out the procedure for healthcare providers submitting medical bills.
4. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - D10-The time limit for filing has expired.
   - P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies. Use only if no other code is applicable.
   - D00-Based on further review, no additional, allowance is warranted.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the requestor support position that the disputed bills were submitted timely?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "D10."

   Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   The respondent states "The carrier maintains the dispute due to untimely filing."

   28 Texas Administrative Code §102.4(h), states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

   The requestor submitted a Fax Send Image report that indicates that the bill was sent on March 4, 2015 at 09:44 am. The Division finds that the requestor has supported position that the disputed bill was submitted timely in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is recommended.

2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare "

   On the disputed date of service the requestor billed CPT codes 97001-GP, G8985-GP-CL and G8984-GP-CN. Codes G8985-GP-CL and G8984-GP-CN are status "Q-Therapy functional information codes" and are not reimbursable.

   Per 28 Texas Administrative Code §134.203(c) (1) (2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery)

Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2015 DWC conversion factor for this service is 56.2.

The Medicare Conversion Factor is 35.7547.

Review of Box 32 on the CMS-1500 the services were rendered in San Angelo, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Rest of Texas.

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable Reimbursement	Total Amount Paid	Total Amount Due
97001-GP	$72.70	$114.27	$0.00	$114.27

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $114.27.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $114.27 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	07/29/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.